December 7, 2009

Cynthia R. Mann
Director of the Centers for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Director Mann:

It has come to our attention that the state of Tennessee has recently begun misinterpreting federal and state laws relating to creditable coverage and Medicaid eligibility under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA). As a result, women may be denied coverage for which they are lawfully eligible. Such a change in interpretation violates the American Recovery and Reinvestment Act of 2009 (ARRA), in which states are ineligible for the stimulus increase in their Medicaid Federal Medical Assistance Percentage (FMAP) if they make eligibility standards, methodologies, or procedures more restrictive than those in effect on July 1, 2008.[1] TennCare has violated this provision by changing its interpretation of the types of insurance coverage that make a breast or cervical cancer patient ineligible for Medicaid. We respectfully request that you review this matter and take appropriate corrective steps as quickly as possible.

In August, [Name Deleted] from Tennessee contacted ACS CAN's Health Insurance Assistance Service (HIAS) about a devastating letter that [Name Deleted] had received from TennCare terminating her Medicaid coverage. TennCare informed her that they had recently

[1] American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5001(f)(1)(A), 123 Stat. 115, 499-500 (2009). ARRA conditions the 6.2 percent FMAP increase on a "Maintenance of Eligibility" restriction under which a state is not eligible for an increase if the eligibility standards, methodologies, or procedures under its state plan are more restrictive than the eligibility standards, methodologies, or procedures under such plan as in effect on July 1, 2008.

changed their policy and according to Tennessee, her supplemental insurance policy from Aflac which offered limited coverage for a specified disease - cancer - made her ineligible to receive Medicaid. We have attached this denial letter for your review.

The American Cancer Society and the American Cancer Society Cancer Action Network do *not* represent [Name Deleted] legally. However, her call to ACS did make us aware of the new interpretation being employed by Tennessee officials. We are concerned that [Name Deleted] may not be the only woman who has experienced a wrongful termination of her Medicaid eligibility. As a nonpartisan grassroots organization dedicated to making the fight against cancer a top priority and the advocacy affiliate of the American Cancer Society, ACS CAN has a particular interest in assuring that our nation's most vulnerable populations have access to available, affordable, adequate, and administratively simple cancer prevention, early detection, and treatment services through the Medicaid and other health care programs.

Tennessee's denial of eligibility contradicts federal and state law. Statutes and regulations concerning the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) indicate that a woman with a limited insurance policy for a specified disease, including cancer, is still eligible for Medicaid through this program. Congress specifically envisioned that women without creditable health coverage, such as [Name Deleted], would have access to Medicaid through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) screening program as long as they meet all other criteria.

Through the Breast and Cervical Cancer Prevention and Treatment Act of 2000, Congress expanded Medicaid to women who are screened for breast and cervical cancer under the Centers for Disease Control and Prevention's (CDC) NBCCEDP screening program.[2] Under the Act, a state may provide Medicaid coverage to women who do not have creditable insurance coverage, are under 65 years old, are otherwise unqualified for Medicaid, have been screened under the CDC program and need treatment for breast or cervical cancer.[3]

To qualify for Medicaid through the NBCCEDP screening, a woman must not otherwise by covered under "creditable coverage," as the term is used in the Health Insurance Portability and Accountability Act (HIPAA, Pub. L. No. 104-191).[4] [Name Deleted] 's

---

[2] Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381 (2000), (codified as amended at 42 U.S.C. §§ 1396a, 1396b, 1396d and 1396r-1b).

[3] 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XVIII), 1396a(aa).

[4] 42 U.S.C. § 1396a(aa)(4). For the HIPAA definition, *See* 42 U.S.C. § 300gg(c).

cancer policy is not a creditable health insurance policy according to law. In drafting HIPAA, Congress envisioned that certain types of insurance, called "excepted benefits," would not be considered "creditable coverage."[5] One type of excepted benefit is coverage only for a specified disease or illness, specifically including cancer.[6] Mrs. [Name Deleted]'s Aflac cancer policy is precisely marketed as a specified disease policy. There is no ambiguity: Women who do not have creditable coverage are eligible for Medicaid; creditable coverage does not include excepted benefits, and one such excepted benefit is an independently offered policy for a specified disease, including cancer.[7]

A cancer-specific policy is also the type of limited and supplemental insurance that HIPAA exempts as an excepted benefit from creditable coverage. Benefits offered separately, such as limited scope dental, vision, long-term care or "such other similar, limited benefits as are specified in regulations" are excepted benefits.[8] Excepted benefits also encompass certain types of supplemental benefits offered as a separate insurance policy, including TRICARE, Medigap and "similar supplemental coverage provided to coverage under a group health plan."[9] Mrs. [Name Deleted]'s cancer policy is offered as a limited

---

[5] 42 U.S.C. § 300gg(c)(1) states that creditable coverage "does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg–91 (c) of this title)."

Under 42 U.S.C. § 300gg-91(c), excepted benefits include:
"(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits
(A) Coverage only for a specified disease or illness."

[6] 42 U.S.C. § 300gg-91(c)(3) *and* 45 C.F.R. § 146.145(c)(4). The regulation *specifically* mentions a cancer policy as an excepted benefit under HIPAA: "Coverage for only a specified disease or illness (for example, cancer-only policies) [. . . .]" 45 C.F.R. § 146.145(c)(4). *See also* 45 C.F.R. § 148.220(b)(3) (listing cancer policies as an example of coverage only for a specified disease or illness, which are not creditable coverage when offered under a separate policy, certificate, or contract of insurance).

[7] Under HIPAA regulations, 45 C.F.R. § 144.103 defines creditable coverage by referring to the group health plan definition, 45 C.F.R. § 146.113(a), which excludes the excepted benefits listed under 45 C.F.R. § 146.145. 45 C.F.R. § 144.103 also refers to the excepted benefits listed under 45 C.F.R. § 148.220.

[8] 42 U.S.C. § 300gg-91(c)(2) *and* 45 C.F.R. § 146.145(c)(3). These are benefits that are offered under a separate policy, certificate, or contract of insurance, and which are not an integral part of a group health plan.

[9] 42 U.S.C. § 300gg-91(c)(4) *and* 45 C.F.R. § 146.145(c)(5). This coverage is the type that is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.

scope benefit that only partially covers one type of illness. Moreover, the cancer policy is offered under a separate contract as a supplement to filling gaps in primary coverage.[10]

CMS's policy guidance also confirms that Tennessee is misinterpreting the law. In its 2001 technical guidance to states, CMS notes that a woman who has "coverage for only a specified disease or illness" or "limited scope coverage" may be eligible for Medicaid assuming she meets all other eligibility.[11] By including women with insurance for only a specified disease or illness in the BCCPTA eligibility, Congress intended to ensure that women without creditable health coverage could access Medicaid.[12]

Tennessee is also misapplying its own Medicaid rules that exempt specified disease policies for purposes of determining whether women are insured. Under TennCare's rules, a woman is eligible for Medicaid if, among other requirements, she has been diagnosed through the CDC site screening and is "uninsured or has health insurance that does not provide coverage for treatment of breast or cervical cancer."[13] For purposes of Medicaid eligibility for breast and cervical cancer, the state rules define uninsured as "any person who does not have health insurance or access to health insurance which covers treatment for breast or cervical cancer."[14]

Like federal law, Tennessee rules exclude a limited benefits policy for a specified disease from the definition of "health insurance."[15] Tennessee rules consider a limited benefits policy a "policy of health coverage for a specific disease **(e.g. cancer)** [. . .]" and

---

[10] 45 C.F.R. § 146.145(c)(5) states that certain supplemental benefits will be excepted only when they are provided under a separate policy, certificate, or contract of insurance.

[11] CMS Technical Policy Questions and Guidance, Question 5 (January 4, 2001).

[12] The legislative history from when Congress passed the BCCPTA supports broad coverage for women. *See* S. Rep. No. 106-323, at 3 (2000): "This definition of creditable health insurance coverage does not include state programs to provide treatment services to women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program. As a result, women currently eligible for state-funded treatment programs will not be disqualified from receiving Medicaid services under this legislation."

[13] Tenn. Comp. R. & Regs. 1200-13-13-.02(3)(c) (2009). *See also* Tenn. Comp. R. & Regs. 1200-13-13-.01(115)(c) (2009), which lists, as persons eligible for TennCare Medicaid under the CDC screening, "A Tennessee resident who is an uninsured woman [. . . .]"

[14] Tenn. Comp. R. & Regs. 1200-13-13-.01(129) (2009).

[15] Tenn. Comp. R. & Regs. 1200-13-13-.01(48)(b)(6) (2009) states that for purposes of determining eligibility, "health insurance" shall not mean "limited benefits policies as defined elsewhere in these rules[.]"

therefore not health insurance.[16] Furthermore, in listing definitions of "Insurance" under TennCare, TennCare's own Operational Protocol says that the types of policies that do not qualify as "insurance" include limited benefits policies, meaning "a policy of health coverage for a specified disease, such as cancer [. . . .]"[17]

Tennessee has apparently changed its own interpretation of federal and state rules regarding insurance coverage and BCCPTA treatment. This shift is very concerning to patients such as [Name Deleted], who are legally eligible for Medicaid. States are currently facing difficult economic times, but they must still be required to follow Medicaid laws. Both federal and state laws relating to BCCPTA screening and treatment state that a woman with a separate insurance policy for a specified disease, such as cancer, is still eligible for Medicaid because these policies are not creditable health coverage. Tennessee has changed its approach to deny eligible breast cancer patients critical Medicaid services. The federal stimulus legislation's Maintenance of Eligibility provision disqualifies states from receiving a stimulus increase in their Medicaid FMAP if they restrict eligibility standards, methodologies, and procedures.[18]

We respectfully ask that you review Tennessee's current interpretation of the BCCPTA and take appropriate corrective action. We thank you for taking the time to review our request. If we can be of assistance or provide additional information, please contact Erin Reidy, Senior Policy Analyst, Policy Team at (202) 661-5754.

Sincerely,

---

[16] [Our bold print]. Tenn. Comp. R. & Regs. 1200-13-13-.01(60) (2009) defines a limited benefits policy as "a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity)."

[17] TennCare Operational Protocol, Attachment B, at 75 (November 2009), available at http://www.tn.gov/tenncare/pol-protocol.html. The cancer-specific individual policy also would not fall under the second part of the definition for uninsured, i.e. "access to health insurance" which covers treatment for breast or cervical cancer, because Tenn. Comp. R. & Regs. 1200-13-13-.01(2) (2009) defines "access to health insurance" as "the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules."

[18] Pub. L. No. 111-5, § 5001(f)(1)(A).

Daniel E. Smith
President